STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaints IN00087244 and IN00087467. Complaint IN00087244 - Substantiated, federal/state deficiencies related to the allegation are cited at F-271, F-281, F-328, F-431, and F-441. Complaint IN000872467 - Substantiated, federal/state deficiencies related to the allegation are cited at F-157, F271, F-282, and F-328. Survey date: March 22, 23, 24, and 25, 2011 Facility number: 000113 Provider number: 155206 AIM number: 100287670 Survey team: DeAnn Mankell, RN, TC Courtney Hamilton, RN (March 24 and 25, 2011) Census bed type: SNF: 4 SNF/NF: 126 Total: 130 Census payor type: Medicare: 17 Medicaid: 91	F0000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Brownsburg Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and Service to the residents of Brownsburg Health Care Center.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Other: 22 Total: 130 Sample: 12 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on March 31, 2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	Based on record review and interview, the facility failed to notify the physician of a resident's low blood sugar for 1 of 3 residents taking insulin injections and for a low oxygen saturation level with a fast respiratory rate for 1 of 4 residents with respiratory needs in a sample of 12 (Resident B). Findings include: 1. Resident B's clinical record was reviewed on 3/22/11 at 5:38 P.M. and again on 3/23/11 at 1:30 P.M. Resident B's diagnoses included, but were not limited to insulin dependent diabetes, deep vein thrombosis, dementia, hypertension, COPD (chronic obstructive pulmonary disease), and Parkinson's disease. Review of Resident B's nurses notes indicated: 03/09/2011 at 10:00 P.M., "@ (at) 4 P Writer entered res. room & found	F0157	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that the resident, resident legal representative and physician is notified of any changes/decline/room move, etc.Resident #B is a very brittle diabetic who is non-compliant with diet. His family brings in and feeds him food that is not on his diet. The 24 hour report for the resident does indicate the physician was called on 3/10/11 at 3am with no new orders given at that time. The physician was called again on 3/10/11 at 8am and was then sent to the hospital for evaluation. All licensed nurses have been inserviced on the facility policy for physician notification and proper documentation of the notification from 3/23/11 and ongoing. All admission and change of condition incidents will be followed up by the DON/designee on a daily basis by checking of the 24 hour report and review of all admissions, transfers and discharges and the Diabetic Flow Sheet for call order compliance.How will other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the deficient practice. No othe resident's were affected by the	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	res. unresponsive & diaphoretic. B/S (blood sugar) 41. Res was given 2 cups vanilla pudding & 120 cc (cubic centimeters) Ensure over 45 min. (minute) time frame. B/S gradually rose to 72 and res became responsive to name. Skin was warm. Res tracked speakers c (with) eyes & answered questions appropriately - 4 P insulin held. Res. consumed 75% of supper c (with) 240 cc fluid intake. 9P B/S 261. HS (bedtime) insulin administered as ordered." Review of the physician's orders for March 2011 indicated an order for "Accu-chek 7 A, 11 A, 4 P, 9 P, Call if B/S < (less than) 60 or > (greater than) 300." The nurses' notes lacked any notation of the physician being notified of the residents low blood sugar. The nurses' notes indicated: 03/10/2011 at 2:45 A.M., "Assessed		practice. Staff inservicing was started on 3/23/11 and is ongoing on the facility policy for physician notification, call orders and where to document that the physician was notified and the response. Also inserviced to policy to notify Medical Director if unable to reach the resident's physician. Documentation of charting will be monitored to reflect that notification has been verified and the response. The 24 hour report will be monitored daily as well as the Diabetic Flow Sheet, call orders and all Admissions, discharges and transfers, on a daily basis by the DON/designee to ensure compliance.What measures will be put into place and what systemic changes wil be made to ensure that the deficient practice does not recur?Staff inservicing was done on 3/23/11 and is ongoing on facility policy for notification of physicain for changes in condition, call orders, etc. The DON/designee will monitor the 24 hour report, Diabetic Flow Sheets, call orders and all admissions, discharges,transfers and documentation for follow-up on a daily basis to ensure compliance.How will the corrective action(s) be monitired to ensure the deficient practice will not recur, ie, what Quality Assurance Program will be put into place and the completion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	BS (blood sugar) at 252. Diaphoretic and warm to touch. Res responded after a couple tries. Had complaints for general discomfort. Administered MAPAP (acetaminophen [fever reducer & pain medication]) 325 ii (2) PO (by mouth). No other interventions wanted (sic). BP (blood pressure) 124/73, P (pulse) 95, R (respirations) 32 (normal respiratory rate is 14-18 breaths per minute), T (temperature) 99.4. Will continue to monitor." 03/10/2011 at 6:00 A.M., "BS 274, BP 135/69, P 80, R 40 T 95.5 O2 78% (oxygen saturation level) [normal levels of oxygen saturation are 92%-100%]. NC (nasal cannula) in place running at 3L (liters). No signs of discomfort. Resident is alert with signs of diaphoresis. Skin is cool to touch. Will continue to monitor." The nurses' notes lacked any notation of the physician being		date?The DON/designee will monitor the 24 hour reports, admissions, discharges, transfers and Diabetic Flow Sheets as well as documentation related to them on a daily basis to ensure compliance. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified of the resident's respiratory rate or the low oxygenation levels. Review of the physician's orders for March 2011 indicated the lack of an order for oxygen administration. The nurses notes indicated: 03/10/2011 at 7:45 A.M., "B/P 133/63, P 75, R 30, Sats 83% on 3 L. of O2 per N/C. Res. is awake. Eyes open. Responsive as normal. Called 8:00 A (name of son) & (name of physician). May send to (name) ER (emergency room) for evaluation. 6 A BS 274. BS at this X (time) 270. had (sic) been 40 @ 4 p. 3-10 (sic) [correct date 3/09/2011] & P.M. Insulin (sic) healed (sic)." 03/10/2011 2:45 P.M., "res. admitted to (name of hospital). nurse (sic) unsure of admitting dx. (diagnoses) being tx'd (treated) for pneumonia & UTI (urinary tract infection)."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the DON (Director of Nurses) on 3/24/2011 at 2:45 PM, she indicated the physician should have been called about the low blood sugar and the respiratory rate, but she did not know if he had been called. Review of the undated policy for "Significant Change of Condition: Physician Notification" provided by the Director of Nurses on 3/24/11 at 4:15 P.M. indicated, "The attending physician will be notified of a change in a resident's condition by a licensed staff member as warranted.... 1. Physician notification is to include but is not limited to: b. Significant change in/or unstable vital signs." This federal tag refers to complaint IN00087467. 3.1-5(a)(2) 3.1-5(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0271 SS=D	Based on observation, interview, and record review, the facility failed to obtain orders for current medications being administered, oxygen, and a dressing change upon the readmission of 2 of 3 residents to the facility in a sample of 12 (Residents B and C). Findings included: 1. Resident B's clinical record was reviewed on 3/22/11 at 5:38 P.M. and again on 3/23/11 at 1:30 P.M. Resident B's diagnoses included, but were not limited to insulin dependent diabetes, deep vein thrombosis, dementia, hypertension, COPD (chronic obstructive pulmonary disease), and Parkinson's disease. Resident B had been transferred to the hospital on March 10, 2011 and had returned to the facility on March 15, 2011 with new medication and treatment orders.	F0271	It is the policy of the facility that when a resident is admitted/readmitted that the facility receives and verifies all orders for the residents care. Resident #B retirned from the hospital and orders were verified by the nurse, including orders from prior to the hospitalization to verify for continuation/discontinuation. The nurse documented that she had verified with the physician. The residents physician follwed him while he was in the hospital and signed his discharge orders. When writing the orders the nurse failed to write the order for Nizoral cream and Granulex(both wer from before the hospitalization). She transcribed to the new Medication Administration Record but did not write the order. On 3/15/11, the residents son requested that he receive oxygen to him more comfortable. The oxygen was applied as a nursing measure but an order was not obatined within 24 hours to maintain the oxygen. An order was obtained on 3/27/11 for the oxygen and orders were written for the Nizoral cream and Granulex as well.Staff were inserviced on 3/23/11 and ongoing on verification of physician orders and checking to ensure all orders have been written as well as placed on the Medication Administration Record. The LPN involved has	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the MAR for March 15-23, 2011 indicated orders for: "Nizoral cream. apply to red areas on face BID." This medication had been charted as applied on 3/16, 3/17, 3/18, 3/19 at 9 AM,m 3/20, 3/21, 3/22, and 3/23 in the morning. "Granulex to bil heels as preventative Q. (every) shift." This medication had been charted as applied on 3/16, 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, and 3/23 for the first 2 shifts. "O2 (oxygen) cont. @ 2 L per NC (nasal cannula)." This medication had been charted as applied on 3/17 on the 7-3 and 3-11 shifts, 3/18 on all 3 shifts, on 3/19 on the 11-7 and 3-11 shift, on 3/20 on all 3 shifts, 3/21 on the 11-7 and 3-11 shifts, 3/22 on all 3 shifts, 3/23 on the 11-7 shift. Review of the physician's re-admission orders for 3/15/2011		received disciplinary action and has been inserviced on physician order verification and transcribing of orders. All admission/readmission oders will be checked for correctness by DON/designee when they occur.Resident #C returned from the hospital with a PermaCath in place. He had been receiving dialysis at the hospital and it had been discontinued. He returned with orders not to dc the catheter. The facility Nurse Practitioner reviewed the discharge orders and did not write any orders to remove the Permacath. The catheter had not been flushed at the hospital and there were no flush orders when admitted. Further follow-up with the hospital revealed that the catheter was left in place for 2 reasons: 1)family was considering possibly taking out of state and restarting dialysis and 2)it was felt the resident was to weak to survive having the catheter removed. The site was checked every shift and the dressing changed whe soiled. The nurse did not write specifically to change the dressing the on the site. The order was written to state: check site every shift and change dressing if soiled. Resident showed no signs/symptoms of infection at the site. Urology was called and the Permacath was removed on 3/28/11 by urology. Inservicing was done on 3/23/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the lack of an order for the Nizoral and Granulex. Further review of the physician's orders indicated the lack of an order for the oxygen on 3/15/2011 through 3/17/2011. During an interview on 3/23/2011 at 2:45 P.M., with ADON #1, she indicated she was unable to find the orders for the Nizoral cream, Granulex, and the oxygen. 2. Resident C's right subclavian permacath site was observed with LPN #5, on 3/24/2011 at 10:55 A.M., she indicated she had changed the dressing that morning as it looked as if it needed it. She indicated it had last been changed on 3/21/2011. She indicated she was not sure when the permacath had been flushed, but she thought it should be flushed at least every shift. Resident C had been readmitted to the facility on 02/25/2011. He was		and is ongoing on verification of orders, writting clear, concise orders and transcribing orders to the MAR/TAR.How will other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?All residents hav ethe potential to be affected by the practice. No other residents were affected by the practice. Staff inservicing was done on 3/23/11 and is ongoing on verification of orders, correct transcribing and documentation. DON/designee will monitor all admission/readmission orders for verification, correctness and documentation. DON/designee monitors all orders daily and will check for correctness and follow-through.What measure(s) will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Staff inservicing was donme from 3/23/11 and is ongoing on verification and documentation orders for admission/readmissions and in general. DON/designee will check all orders daily as well as admission/readmission orders when they occur for correctness and appropriate transcription to the MAR/TAR.How will the corrective action(s) be monitored to ensure the deficient practice does not recur, ie, what Quality Assurance Program will be put into place and the completion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had a right subclavian permacath in place, which had been used for dialysis, but the dialysis treatments had been stopped before he returned to the facility. Resident C's clinical record was reviewed on 3/22/11 at 7:05 P.M. and additionally reviewed on 1/24/11 at 9:15 A.M. Resident C's diagnoses included, but were not limited to, hypertension, multiple myeloma, dementia, and C-diff. Resident C's physician's orders for February 25, 2011 and March 2011 had an order for "Check (R) (right) subclavian permacath q (every) shift for redness, swollen, drainage, & placement." Review of the TAR (treatment administration record) for February and March 2011 indicated this had been done.		date?The DON/designee will monitor all admission/readmission orders as thy occur and will check all orders on a daily basis for follow-up, correctness and correct transcription to the MAR/TAR. Any continued concerns will be addressed at the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These orders lacked an order to change the dressing or to flush the catheter. Review of the undated policy, provided by the MDS coordinator on 3/25/2011 at 10:15 A.M., for "1. Physician's orders/transcribing for new and re-admitted residents" had the following "....If the Physician's Orders do not arrive with the resident the Physician should be called and orders received per telephone.... 2. Items to be included in the Orders (not an all inclusive list):...Routine and PRN (as needed) medications, Treatments...." During an interview with the DON on 3/24/2011 at 11:30 A.M., she indicated the physician had not wanted the permacath removed. She indicated there were no orders to change the dressing or to care for the permacath. This federal tag relates to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	complaints IN00087467 and IN00087244. 3.1-30(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0281 SS=D	Based on interview and record review, the facility failed to ensure a pain patch was applied by a licensed staff member for 1 of 3 residents in a sample of 12 (Resident A). Findings include: 1. During the facility tour on 3/22/2011 at 2:43 PM, with RN #1, she didn't indicate Resident A had pain issues. Resident A's clinical record was reviewed on 3/22/2011 at 4:55 PM. Resident A's diagnoses included, but were not limited to, congestive heart failure, depression, and osteoarthritis pain. Resident A's physician's orders for March 10-31, 2011 indicated an order for "Lidoderm (used to relieve pain) 5% patch to (R) (right) hip @ HS. Off in AM."	F0281	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that services provided meet professional standards.Resident #A received a Lidoderm patch. Patches and all medications ar eto be administered by a licensed nurse or qualified medication aide(QMA). RN#2 has been disciplined and reinserviced on the fsacility medication administration policy. Inservicing was done on 3/23/11 and is ongoing on the facility medication administration policy. Other residents on the care unit were interviewed and all state medications given to them ony by nurses and QMA's. C.N.A.'s and other nurses who work the unit interviewed and all but one stated have not given meds or left meds for an aide to place. Nurse disciplined and reinserviced.How will other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?All residents receiving medications have the potential to be affected. No other residents were affected by the practice. DON/designee will monitor by observation and resident interviews daily for 4 weeks or until resolution occurs then randomly. Inservicing was done on 3/23/11 and is ongoing on the facility medication	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Alert and oriented Resident A was interviewed on 3/22/2011 at 6:18 PM. She indicated she had a pain patch the CNA's would put on her at night time when she went to bed because the nurse was "too busy" to place it on her. She indicated she didn't want to get anyone in trouble for doing this. During an interview at 8:25 PM, on 3/22/2011, with CNA #3, she indicated the nurse always puts Resident A's pain patch on her. During an interview at 8:26 PM with RN #2, she indicated she would pass Resident A's medications later as the resident liked them later when she went to bed. She indicated she would place the resident's pain patch when she went to bed around 10 PM. She indicated sometimes the CNA's would place the resident's pain patch when she left it in the room for them to place it on the resident once she got into bed. She		administration policy.What measures wil be put into place and waht systemic changes will be made to ensure the deficient practice does not recur?Staff inservicing was done on 3/23/11 and is ongoing on the facility medication administration policy for licensed nurses and QMA's. C.N.A.'s were also inserviced to not give medication even if told to by a nurse. DON/designee will check daily for 4 weeks or until resolution occurs by direct observation and resident interview that are in compliance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what Quality Assurance Program will be put into place and the completion date?DON/designee will monitor daily for 4 weeks or until resolution occurs then randomly by observation and resident interview that are in compliance. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she would leave the pain patch at the resident's bedside and some of the CNA's would place it on the resident. She indicated if the CNA was not comfortable placing the pain patch then she would place it. She indicated CNA #3 had never placed the pain patch, but she named CNA's who might have placed the pain patch. She indicated that none of those CNA's were QMA's (qualified medication aides). Review of the job description for charge nurse provided by the MDS coordinator on 3/25/2011 at 10:25 AM, indicated the nurse was to "Prepare and administer medications as ordered by the physician." Review of the job description for the Certified Nursing Assistant provided by the MDS coordinator on 3/25/2011 at 10:25 AM, indicated the CNA had no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication administration duties. Review of the 2007 policy for "Medication Administration General Guidelines" provided by the MDS coordinator on 3/25/2011 at 10:25 AM, indicated "....5. The person who prepares the dose for administration is the person who administers the dose...." This federal tag refers to complaint IN00087244. 3.1-35(g)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	Based on record review and interview, the facility failed to follow physician's orders by calling a physician as ordered for 1 of 3 residents with insulin injections in a sample of 12 (Resident B). Findings include: 1. Resident B's clinical record was reviewed on 3/22/11 at 5:38 P.M. and again on 3/23/11 at 1:30 P.M. Resident B's diagnoses included, but were not limited to insulin dependent diabetes, deep vein thrombosis, dementia, hypertension, COPD (chronic obstructive pulmonary disease), and Parkinson's disease. Review of Resident B's nurses notes indicated: 03/09/2011 at 10:00 P.M., "@ (at) 4 P Writer entered res. room & found res. unresponsive & diaphoretic. B/S (blood sugar) 41. Res was given 2 cups vanilla pudding & 120	F0282	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that services be provided by a qualified person per the resident's plan of care.Resident #B had an occurence of low blood sugar on 3/9/11. The nurses note did not state that the physician had been called per the plan of care, call orders and for a change in conditon. However, it was on the 24 hour nurses report with a notation of no new orders.A late entry to the record has been made to reflect this information. Staff have been inserviced from 3/23/11 and ongoing to document in the medical record that the physician has been notified per the call orders, change in condition and resident plan of care; and the response to the notification.How will other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the practice. Staff have been inserviced on 3/23/11 and ongoing to documenting physician notification and documenting in the chart. Also, inserviced to calling for change in conditon, results outside of call order parameters or plan of care. DON/designee will monitor for changes through the 24 hour	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cc (cubic centimeters) Ensure over 45 min. (minute) time frame. B/S gradually rose to 72 and res became responsive to name. Skin was warm. Res tracked speakers c (with) eyes & answered questions appropriately - 4 P insulin held. Res. consumed 75% of supper c (with) 240 cc fluid intake. 9P B/S 261. HS (bedtime) insulin administered as ordered." Review of the physician's orders for March 2011 indicated an order for "Accu-chek (fingerstick blood sugar testing) 7 A, 11 A, 4 P, 9 P, Call if B/S < (less than) 60 or > (greater than) 300." The nurses' notes lacked any notation of the physician being notified of the resident's low blood sugar as ordered. Review of the care plan, dated 12/24/2010, for the problem of "Potenial (sic) for unstable blood sugar levels due to Insulin		nurses report on a daily basis and will monitor for documentation, call order and plan of care changes. No other resident were affected by this practice.What measures will be put into place and what systemis changes will be made to ensure that the deficient practice does not recur?Staff inservicing was done on 3/23/11 and is ongoing on physician notification, call orders, plan of care and documentation of the information in the resident chart. DON/designee will monitor daily by checking the 24 hour nurses reports and monitoring of the resident record, plan of care and documentation to reflect changes/no changes from the physician notification.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what Quality Assurance Program will be put into place and the completion date?DON/designee will monitor the 24 hour nurses report, new orders and MARS/TARS daily for any changes. Plan of care will be updated to reflect any changes. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee till resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Dependent Diabetes Mellitus" had a goal of "Blood sugars will be between 70 and 400 mg/dl. Will be free of s/s (signs/symptoms) of hypo/hyperglycemia." The approaches included, but were not limited to, "....Monitor for signs/symptoms ob blood sugar extremes: diaphoresis, slurred speech, confusion, drowsiness, agitation, and notify Dr. of abnormals. Insulin as ordered...." During an interview with the DON (Director of Nurses) on 3/24/2011 at 2:45 PM, she indicated the physician should have been called, but she did not know if he had been called. This federal tag refers to complaint IN00087467. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	Based on observation, record review and interview, the facility failed to obtain orders for oxygen for 1 resident, failed to follow orders for oxygen for 1 resident, failed to ensure oxygen humidification for 1 resident for 3 of 4 residents with oxygen therapy in a sample of 12 (Residents B, C, and J). Findings include: 1. During the facility tour with LPN #1, on 3/22/11 at 2:50 P.M., she indicated Resident B had a diagnosis of diabetes. He had oxygen which was being delivered by nasal cannula. Resident B was observed on 3/24/2011 at 9:10 A.M., lying in bed with oxygen being delivered at 2 liters per nasal cannula. Resident B's clinical record was reviewed on 3/22/11 at 5:38 P.M. and again on 3/23/11 at 1:30 P.M.	F0328	What corrective action(s) will be accomplished for those resident affected by the deficient practice?It is the policy of the facility that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy; ureterostomy or ileostomy care; tracheostomy care; tracheal suctioning; rspiratory care; foot care; and prosthesis.Resident #B had oxygen place as a nursing measure per the request of his son on 3/15/11 for comfort. The resident continued on oxygen for greater than 24 hoyurs without obtaining a physicians order to continue the oxygen. A physicians order was obtained and the resident continues on oxygen. Staff inservicing was done on 3/23/11 and is ongoing to facility Oxygen Administration Policy and that oxygen cannot be continued as a nursing measure for more than 24 hours.Resident #C had an order for oxygen a 3 liters per nasal cannula continously. The resident would remove his oxygen and would adjust the dials due to confusion. The resident soxygen has now been discontinued as his respiratory status has improved.Staff inservicing was done on 3/23/11 and is ongoing on oxygen administration policy and to continously check resident to ensure the oxygen is on the	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident B's diagnoses included, but were not limited to insulin dependent diabetes, deep vein thrombosis, dementia, hypertension, COPD (chronic obstructive pulmonary disease), and Parkinson's disease. Review of Resident B's nurses notes indicated: 03/10/2011 at 6:00 A.M., "BS 274, BP 135/69, P 80, R 40 (normal respiratory rate is 14-18 breaths per minute), T 95.5 O2 78% (oxygen saturation level) [normal levels of oxygen saturation are 92%-100%]. NC (nasal cannula) in place running at 3L (liters). No signs of discomfort. Resident is alert with signs of diaphoresis. Skin is cool to touch. Will continue to monitor." 03/18/2011 at 10:30 A.M.,"....O2 Sat on 2 L per N/C (nasal cannula)...." 03/21/2011 at 1:00 P.M., "....Clear		setting are correct.Resident #J was checked and the oxygen water bottle had approximately 3-4 ounces of liquid still in the bottle. The oxygen bottle is changed when the fluid level is low and the oxygen tubing is changed every 72 hours. Inservicing was done from 3/23/11 on the oxygen administration policy, filling of the oxygen water bottles and changing of the oxygen tubing. DON/designee will check oxygen water bottles daily on rounds to ensure have fluid in them.How will the other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?No other esidents were affected by the practice. All residents receiving oxygen have the potential to be affected. DON/designee and unit nurses will monitor oxygen water bottles for fluid level and will monitor for resident compliance with wearing oxygen as ordered and that the settings are correct. DON/designee will monitor through observation, checking of new orders and 24 hour report for residents on oxygen and for a physicians order for the oxygen. Monitoring will be daily for DON/designee and each shift for unit nurses. Inservicing was done on 3/23/11 and is ongoing on oxygen administration policy and monitoring of fluid level in water bottle, and that resident is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	breath sounds. O2 Sat. 97%...." Review of all of the physician's orders for March 2011 indicated the lack of an order for oxygen administration. During an interview with LPN #4 (ADON #1) on 3/23/2011 at 4:59 P.M., she indicated oxygen could be administered to residents as a nursing measure and a physician's order was not needed. 2. During the facility tour on 3/22/2011 at 2:46 P.M., with RN #1, Resident C was not identified as needing oxygen. Resident C was observed on 3/22/2011 at 8:05 P.M. He did not have oxygen on at this time. Resident C was observed on 3/24/2011 at 10:55 A.M., with oxygen on at 3.5 liters per minute. Resident C's clinical record was		compliant with oxygen as ordered, as well as having a physician's order in place if is used for more than 24 hours.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Inservicing was done from 3/23/11 and ongoing on oxygen administration policy, oxygen water bottle fluid levels, resident compliance with oxygen, checking the correct setting and obtaining a physician order if used for more than 24 hours as a nursing measure.DON/designee will check daily for new orders on the 24 hour report and by reviewing new orders. Will also check oxygen water bottle fluid level and for resident compliance diring daily rounds. Unit nurses will check every shift for compliance and water levels.How will the corrective action(s) be monitored to ensure the deficient practice does not recur, ie, what Quality Assurance Program will be put into place and the completion date?DON/Designee/unit nurses willmonitor daily(every shift for unit nurses), the fluid level in the water bottles, for correct settings and resident compliance as well as th e24 hour report and all new orders. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 3/22/11 at 7:05 P.M. Resident C's diagnoses included, but were not limited to, hypertension, multiple myeloma, dementia, and C-diff. Resident C's February 25, 2011 physician orders indicated an order for continuous oxygen on at 3 Liters per nasal cannula. This order was not changed on any of the February or March 2011 orders.		be monitored by the Administrator/DON/ designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	3. A current undated facility policy provided by the Assistant Director of Nursing on 03/24/11 at 8:45 A.M., indicated staff is to "...refill humidifier bottle on the O2 (oxygen) regulator daily with sterile distilled water to the line indicated on the bottle or use prefilled bottles..." Resident J's record was reviewed on 03/25/11 at 9:55 A.M. Diagnoses included but not limited to: COPD (chronic obstructive pulmonary disorder), CHF (congestive heart failure), hypoxia, and macular degeneration. Medicine Administration Recap, dated 03/01/11, indicated a physicians order for 2 liters of continuous oxygen per nasal cannula to maintain oxygen saturation above 90%. There were no physician orders indicating when to change the oxygen tubing or sterile water bottles on the humidifier. Observation of Resident J's room on 03/24/11 at 9:05 A.M., indicated an undated empty bottle of sterile water on his O2 regulator. An interview with LPN #2 on 3/24/11 at 9:15 A.M., indicated "the bottles are	F0328	What corrective action(s) will be accomplished for those resident affected by the deficient practice?It is the policy of the facility that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy; ureterostomy or ileostomy care; tracheostomy care; tracheal suctioning; rspiratory care; foot care; and prosthesis.Resident #B had oxygen place as a nursing measure per the request of his son on 3/15/11 for comfort. The resident continued on oxygen for greater than 24 hoyurs without obtaining a physicians order to continue the oxygen. A physicians order was obtained and the resident continues on oxygen. Staff inservicing was done on 3/23/11 and is ongoing to facility Oxygen Administration Policy and that oxygen cannot be continued as a nursing measure for more than 24 hours.Resident #C had an order for oxygen a 3 liters per nasal cannula continously. The resident would remove his oxygen and would adjust the dials due to confusion. The resident soxygen has now been discontinued as his respiratory status has improved.Staff inservicing was done on 3/23/11 and is ongoing on oxygen administration policy and to continously check resident to ensure the oxygen is on the	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	usually changed by night shift with the tubing every seven days." This federal tag refers to complaints IN00087244 and IN00087467. 3.1-47(a)(6)		setting are correct.Resident #J was checked and the oxygen water bottle had approximately 3-4 ounces of liquid still in the bottle. The oxygen bottle is changed when the fluid level is low and the oxygen tubing is changed every 72 hours. Inservicing was done from 3/23/11 on the oxygen administration policy, filling of the oxygen water bottles and changing of the oxygen tubing. DON/designee will check oxygen water bottles daily on rounds to ensure have fluid in them.How will the other residents affected by the same deficient practice be identified and what corrective action(s) will be taken?No other esidents were affected by the practice. All residents receiving oxygen have the potential to be affected. DON/designee and unit nurses will monitor oxygen water bottles for fluid level and will monitor for resident compliance with wearing oxygen as ordered and that the settings are correct. DON/designee will monitor through observation, checking of new orders and 24 hour report for residents on oxygen and for a physicians order for the oxygen. Monitoring will be daily for DON/designee and each shift for unit nurses. Inservicing was done on 3/23/11 and is ongoing on oxygen administration policy and monitoring of fluid level in water bottle, and that resident is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliant with oxygen as ordered, as well as having a physician's order in place if is used for more than 24 hours.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Inservicing was done from 3/23/11 and ongoing on oxygen administration policy, oxygen water bottle fluid levels, resident compliance with oxygen, checking the correct setting and obtaining a physician order if used for more than 24 hours as a nursing measure.DON/designee will check daily for new orders on the 24 hour report and by reviewing new orders. Will also check oxygen water bottle fluid level and for resident compliance diring daily rounds. Unit nurses will check every shift for compliance and water levels.How will the corrective action(s) be monitored to ensure the deficient practice does not recur, ie, what Quality Assurance Program will be put into place and the completion date?DON/Designee/unit nurses willmonitor daily(every shift for unit nurses), the fluid level in the water bottles, for correct settings and resident compliance as well as th e24 hour report and all new orders. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be monitored by the Administrator/DON/ designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	Based on observation, record review, and interview, the facility failed to ensure a medication cart and treatment cart were locked when not in use on 2 of 8 halls. This practice had the potential to affect 32 residents in the facility population of 130. (200 hall medication cart and 400 hall treatment cart). Findings include: 1. The 400 hall treatment cart was observed on 3/22/2011 at 5:30 PM, 6:50 PM, and 8:20 PM. It was unlocked during all observations. There was no staff or residents near the cart during each observation. 2. The 200 hall medication cart was observed with LPN #2 on 3/23/3011 at 12:01 PM. The medication cart was not in use, but was in the hallway and was not locked. LPN # 2 said, "It should have been locked and locked it."	F0431	What corrective action(s) will be accomplished for those rsidents found to be affected by the deficient practice?No residents were affected by the deficient practice.The 400 hall treatment cart was found to be unlocked on 3/22/11 on 3 separate occassions with the nurse not at the cart. The LPN assigned to 400 hall has been terminated due to this being addresssed with him on a previous occassion. Staff inserviced on 3/23/11 and ongoing to medication administration policy and that medication and treatment carts ar eto be locked at all times if nurse/QMA is not at the cart.The 200 hall medication cart was found unlocked on 3/23/11. RN was disciplined. Stated she was just inside the door of the room but cart was not within her sight. Staff inserviced on 3/23/11 and ongoing to facility medication administration policy and carts to be locked at all times when nurse/QMA not present.How willothe residents affected by the same deficient practice be identified and what corrective action(s) will be taken.All residents have the potential to be affected. Nio resident was affected by the practice. Inservicing was done on 3/23/11 and is ongoing on the medication administration policy and the importance of locking the cart when not in sight of the	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the 2007 policy for "Medication Administration General Guidelines" provided by the MDS coordinator on 3/25/2011 at 10:25 AM, indicated "....17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to personnel administering medications when unlocked...." This federal tag relates to complaint IN00087244. 3.1-25(m)		nurse/QMA.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Staff inservicing donme on 3/23/11 and ongoing on facility medication administration policy. DON/designee will check carts daily at different times for 4 weeks or until resolution then randomly to monitor compliance.How will thew corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what Quality Assurance Program will be put into place and the completion date?DON/designee will monitor daily at different times for 4 weeks or until resolution then randomly to ensure compliance. Any continued concerns will be addressed at the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	Based on observation, interview, and record review, the facility failed to have signs posted for 1 resident in isolation and supplies in the carts at the doorways of 2 residents in isolation for 3 residents in isolation in a sample of 12 (Residents C and L). Findings included: 1. During the facility tour on 3/22/2011 at 2:46 P.M., with RN #1, Resident C was identified as being in isolation for C.diff. The door and the cart in front of the door lacked any sign to indicate the resident was in isolation or to see the nurse before entering the room. There was a staff member who didn't have a gown on in the room with the resident during this tour. The DON, who was in the hallway during the tour, indicated there should be a sign on the dresser, but she couldn't find the sign. She indicated she didn't think the resident was still being treated for	F0441	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that it maintains an Infection Control Program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.Resident #C was admitted with C-Diff. He had an isolation cart outside his room. The signage was missing from the door on tour, It was immediately replaced. There were no gowns in the cart but they were accessible in the hallway closet. Facility policy says a gown is worn if you think you may soil your clothes. Gowns were placed in the isolation cart drawers. The resident is incontinent and wears a brief. Resident was still on Vancomycin at the time so a repeat culture could not be done. Resident is currently out of isolation after returning from the hospital(had Permacath removal). The hospital noted that the resident has loose stools but not C-Diff. Inservicing was done on 3/23/11 and is ongoing to isolation procedures for all nursing staff. DON/designee will monitor isolation carts daily to ensure proper equipment is present and that signage is in place. C.N.A. assignment sheets have been updated to reflect to show who is in isolation.Resident #L returned	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C.diff. The cart in front of Resident C's door was observed on 3/22/2011 t 4:30 P.M. The cart didn't have any gowns in the drawers. Resident C's clinical record was reviewed on 3/22/11 at 7:05 P.M. Resident C's diagnoses included, but were not limited to, hypertension, multiple myeloma, dementia, and C-diff.		from the hospital on 3/24/11 on the 3/11 shift. Carts were stocked with gowns and all equipment. Signage was placed on the door. C.N.A. assignment sheet was updated on 3/25/11 and C.N.A.'s received verbal report till sheet was updated on the morning of 3/25/11. Inservicing was done on 3/23/11 and ongoing on isolation policy for all nursing staff. DON/designee will monitor daily to ensure cart is stocked with equipment and correct signage is in place. Assignment sheets for aides wil be updated with new changes.How will other residents affected by the same practice be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the practice. No other residents were affected by the practice. Inservicing was done on 3/23/11 and is ongoing on isolation policy and proper signage and stocking of the isolation carts. DON/designee will monitor carts daily for proper equipment, signage and updated C.N.A. assignment sheets.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Staff inservicing was done on 3/23/11 and is ongoing on isolation policy, proper equipment, correct signage and aide assignment sheets. DON/designee will monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			isolation carts, signage and aide assignment sheets daily for complianceHow will the corrective action(s) be monitored to ensure that the deficient practice does not recur, ie, what Quality Assurance Program will be put into place and the compliance date?DON/designee will monitor daily for compliance of correct equipment, signage, isolation policy and aide assignage sheets. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	Observation on 3/25/2011 at 9:40 A.M., of Resident C's room indicated an isolation cart and sign outside of the room. The isolation cart contained gloves and red bags. The isolation cart did not contain any protective gowns. An updated CNA assignment sheet provided by the MDS Coordinator on 03/25/11 at 9:55 A.M., dated 03/23/11, did not indicate Resident C was in contact isolation. A current undated facility policy titled, "Isolation" provided by the MDS Coordinator on 03/25/11 at 10:15 A.M. indicated "isolation precautions will be instituted per physician order, or per direction of the Director of Nursing, Assistant Director of Nursing, or Administrator as a precautionary measure. The policy also indicated the facility will "...make sure cart is stocked with appropriate equipment." A current undated facility policy titled, "Transmission Based Precautions" provided by the MDS Coordinator on 03/25/11 at 10:15 A.M., indicated staff will "...wear a gown when entering a room if you anticipate soiling or clothing from resident or environment."	F0441	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that it maintains an Infection Control Program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.Resident #C was admitted with C-Diff. He had an isolation cart outside his room. The signage was missing from the door on tour, It was immediately replaced. There were no gowns in the cart but they were accessible in the hallway closet. Facility policy says a gown is worn if you think you may soil your clothes. Gowns were placed in the isolation cart drawers. The resident is incontinent and wears a brief. Resident was still on Vancomycin at the time so a repeat culture could not be done. Resident is currently out of isolation after returning from the hospital(had Permacath removal). The hospital noted that the resident has loose stools but not C-Diff. Inservicing was done on 3/23/11 and is ongoing to isolation procedures for all nursing staff. DON/designee will monitor isolation carts daily to ensure proper equipment is present and that signage is in place. C.N.A. assignment sheets have been updated to reflect to show who is in isolation.Resident #L returned	04/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Resident L's record was reviewed on 03/25/11 at 10:20 A.M., diagnoses included but were not limited to C-Diff, dehydration, atrial fibrillation, malnutrition, hypothyroidism, lower extremity edema, and thrombocytopenia. Physician admission orders dated 03/23/11 indicated Resident L was discharged from the hospital with C-Diff. Nurses notes dated 03/24/11 at 10 P.M., indicated Resident L was in contact isolation for C-Diff. Observation of Resident L's room on 03/25/11 at 9:45 A.M., indicated a sign and isolation cart outside the residents room. The isolation cart contained gloves, masks, red and yellow bags. The isolation cart did not contain any protective gowns. Interview with CNA #1 on 03/25/11 at 9:15 A.M., indicated "...I don't know why he is in isolation. I have been off for a while. I would ask someone before I went in there...If I needed a gown, I would get one of the linen ones, if there were none in the dresser." Interview with LPN #3 on 03/25/11 at 9:50 A.M., indicated "...CNA's are told who is in isolation and why by their CNA		from the hospital on 3/24/11 on the 3/11 shift. Carts were stocked with gowns and all equipment. Signage was placed on the door. C.N.A. assignment sheet was updated on 3/25/11 and C.N.A.'s received verbal report till sheet was updated on the morning of 3/25/11. Inservicing was done on 3/23/11 and ongoing on isolation policy for all nursing staff. DON/designee will monitor daily to ensure cart is stocked with equipment and correct signage is in place. Assignment sheets for aides wil be updated with new changes.How will other residents affected by the same practice be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the practice. No other residents were affected by the practice. Inservicing was done on 3/23/11 and is ongoing on isolation policy and proper signage and stocking of the isolation carts. DON/designee will monitor carts daily for proper equipment, signage and updated C.N.A. assignment sheets.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?Staff inservicing was done on 3/23/11 and is ongoing on isolation policy, proper equipment, correct signage and aide assignment sheets. DON/designee will monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assignment sheets". Interview with the MDS Coordinator on 3/25/11 at 10:15 A.M., indicated "We only update the CNA assignment sheets when there are changes". Interview with CNA #2 on 03/24/11 at 10:55 A.M., indicated "I don't know all the residents that are in isolation. I float here in the facility so I don't know." Interview with the Director of Nursing on 03/25/11 at 12:30 P.M., indicated "the unit managers are responsible for updating the CNA assignment sheets as needed and they are looked at weekly." An updated CNA assignment sheet provided by the MDS Coordinator on 03/25/11 at 9:55 A.M., dated 03/23/11, did not indicate Resident L was in contact isolation. This federal tag relates to complaint IN00087244. 3.1-18(b)(2)		isolation carts, signage and aide assignment sheets daily for complianceHow will the corrective action(s) be monitored to ensure that the deficient practice does not recur, ie, what Quality Assurance Program will be put into place and the compliance date?DON/designee will monitor daily for compliance of correct equipment, signage, isolation policy and aide assignage sheets. Any continued concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE